DELTA DENTAL®

Federal Services
P.O. Box 537007
Sacramento, CA 95853-7007

☐ DENTIST'S STATEMENT OF COMPLETED SERVICES

☐ PRE-DETERMINATION REQUEST

M613542 (10/00)

PATIENT

1. PATIENT NAME | 2. RELATIONSHIP TO PRIMARY ENROLLEE: SELF / SPOUSE / CHILD / OTHER _____ | 3. SEX: M / F | **4. PATIENT BIRTHDATE** MO DAY YEAR | 5. IF FULL TIME STUDENT: SCHOOL / CITY

6. PRIMARY ENROLLEE NAME: **FIRST** **MIDDLE** **LAST** | **7. RETIREE SOCIAL SECURITY NUMBER** | **8. PRIMARY ENROLLEE BIRTHDATE** MO DAY YEAR

MAILING ADDRESS | APT. NO. | PHONE NO.

CITY, STATE | **ZIP CODE**

☐ **IS THIS A NEW ADDRESS?**

COB

9. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? IF YES, COMPLETE ITEMS 10 THROUGH 14 YES _____ NO _____

10a. AMOUNT PAID BY OTHER CARRIER

10b. IS OTHER CARRIER PRIMARY____ SECONDARY____

10c. GROUP NUMBER OF OTHER CARRIER

11. NAME AND ADDRESS OF CARRIER, ITEM 9

12a. EMPLOYEE NAME, ITEM 9

12b. EMPLOYEE/SOCIAL SECURITY NUMBER, ITEM 9

12c. EMPLOYEE BIRTHDATE MO DAY YEAR

13. RELATIONSHIP TO PATIENT SELF / SPOUSE / PARENT / OTHER ____

14. NAME AND ADDRESS OF EMPLOYER

DENTIST

15. DENTIST NAME

16. MAILING ADDRESS

CITY, STATE | **ZIP CODE**

19. DENTIST SOC. SEC. NO. OR T.I.N.

20. DENTIST LICENSE NO.

21. DENTIST PHONE NO.

17. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ☐ YES ☐

18. IS TREATMENT RESULT OF AN ACCIDENT? NO ☐ YES ☐

22. IS TREATMENT FOR ORTHODONTICS? NO ☐ YES ☐

IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.

IF SERVICES ALREADY COMMENCED:

DATE APPLIANCE PLACED: __/__/__

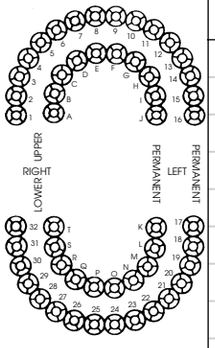
MONTHS OF TREATMENT: _____

23. X-RAY ENCLOSED? YES NO HOW MANY?

24. PLACE OF TREATMENT
OFFICE / HOSP. / ECF / OTHER

FIRST VISIT DATE
CURRENT SERIES: __/__/__

TOOTH GUIDE



25. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN. NOTE: SERVICES NOT DATED WILL BE PRE-DETERMINED.

	TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MM DD YYYY	PROCEDURE NUMBER	FEE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						

DOCUMENTATION/REMARKS

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.

SIGNATURE OF PATIENT
(OR PARENT OR GUARDIAN) _____

DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

TOTAL FEE CHARGED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION.

DENTIST SIGNATURE

DATE

TRICARE 10/00